December 12, 2018

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: **Comments on the Draft Final Report: Modernization of the Maryland Certificate of Need Program**

Dear Ben:

I am submitting comments today on behalf of the members of the Health Facilities Association of Maryland (HFAM), regarding the December 11, 2018 Draft Final Report on the Modernization of the Maryland Certificate of Need Program (the "Report"). For the benefit of Commissioners reviewing Stakeholder comments and to place our comments on the Report in context, we wish to point out that HFAM members provide extensive long term and post-acute care services in skilled nursing and rehabilitation centers ("Centers") regulated by the Maryland Health Care Commission (MHCC), as Comprehensive Care Facilities (CCFs).

HFAM members operate Centers in every Maryland jurisdiction, providing high acuity services that return individuals to their homes with improved function and quality of life. Centers play a vital role in the continuum of care, avoiding and mitigating hospitalizations and rehospitalizations. Centers are an integral part of the statewide commitment to meeting the terms of the Total Cost of Care (TCOC) agreement with the Centers for Medicare and Medicaid Services. In commenting, we wish to express our support for, and endorsement of, the comments on the Report offered by Lifespan Network.

Attached are earlier letters we submitted throughout the process. We offer them to minimize duplication in this letter and to highlight our support for the process, with the caveat that we have continued to express concern about key issues.

We salute the MHCC for its effort to respond to the directive of the Maryland Senate Finance Committee and House Government Operations Committee to examine the Certificate of Need (CON) process. The MHCC has, we acknowledge, provided opportunities for stakeholder input and representation. Much has been accomplished through the process and there is a great deal to be supported. The areas of focus on page 2 of the Report and the Principles of Reform on page 8 provide a foundation for these efforts to modernize the CON process. However, particularly in the area of long term and post-acute care provided by Centers regulated as CCFs, there are specific areas in the Report that demonstrate a disparate treatment of CCFs, as compared to other provider groups and reflects recommendations that risk harm to the health care delivery system, in such a way that is counter to the guiding principles the MHCC seeks to address.

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Rather than fostering innovation among CCFs in support of the TCOC model, the Report reflects disparate treatment of CCFs in a way that risks harm to this vital part of the health care delivery system.

On page 9, as a "cross-cutting" issue the Report states the CON process should allow for innovation in care delivery when it is consistent with the objectives of the TCOC model. This principle is addressed throughout the report, culminating with a recommendation on page 33 that among the regulatory reforms that should be started immediately is an ability to waive docketing requirements or other considerations for a capital project the Health Services Cost Review Commission (HSCRC) endorses as a viable approach for reducing the total cost of care under the TCOC model. This approach is spread throughout the Report in referencing potential recommendations for the various State Health Plan chapters governing the CON process for various provider groups including the discussion of the CCF chapter on page 20 of the Report.

It is important that the Report make clear that the recommendation, based on the TCOC model, relating to capital projects involving additional beds remains subject to the bed need methodology, so that docketing is predicated on the requirement that there be CCF bed need under the State Health Plan. The Report continues to include among "Potential Solutions" on page 18 the possibility that the MHCC could "[p]ermit docketing of applications that have no need if the proposal is aligned with the TCOC model." As we have continued to stress, it is contrary to the guiding principle of fostering innovation supporting the TCOC model to open the door to the approval of new CCFs for which there is no bed need under the State Health Plan. There is, instead, risk of harm to the existing health care delivery system, including CCFs that are already substantially investing in innovation efforts in support of the TCOC model. In an effort to be supportive, HFAM has suggested language that would first, ensure that existing CCFs have had the opportunity to demonstrate collaborative innovation with hospitals, before new facilities for which there is no need are awarded CONs.

Substantial and detailed discussions are essential relating to the risk of CON approvals for CCF applications where there is no bed need under the State Health Plan relating to MHCC-established quality standards.

We appreciate and endorse the first Potential Solution on page 18 that State Health Plan CCF Chapter modifications should reflect consultation with Stakeholders and Commissioners. However, we are concerned about the Potential Solution on page 18 that docketing of applications for new facilities may be possible based on a percentage of CCFs with rankings below MHCC-established quality standards.

Quality and optimal outcomes for Center residents is of paramount concern to HFAM and our members. Our concern is with the risk of damage to the services existing Centers provide to residents and the health care delivery system by approving CONs for facilities for which there is no need. This was addressed in our prior comments. The discussion leading to the Report included debates about the role of the CMS Five Star scoring system as one element of a review of Center performance. We appreciate the reference to standards the MHCC may establish in the future without specific reference to a special rule for the CMS Five Star system. Such MHCC standards should be the product of a fulsome review of available and meaningful metrics for assessing quality, and consideration of the role and existing authority of multiple agencies in assessing facility performance and outcomes.

We support the decision not to include in the Report a corresponding Reform Recommendation on pages 19 and 20. We infer, and wish to confirm, that this will be the subject of future discussion, while reiterating that CON approval facilities for which there is no need is not the solution.

We seek a Reform Recommendation to address the Medicaid Memorandum of Understanding Problem.

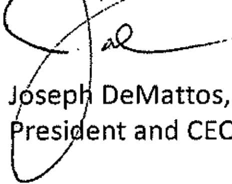
On page 18, the Report properly notes that there is an issue relating to the need to eliminate the specific percentage in Medicaid Memoranda of Understanding that CCFs are required to sign to obtain a CON. We observe with concern that there is no corresponding Potential Solution to address the stated issue and that this may signal an unwillingness to address the issue.

The data demonstrate that there is no Center access to care problem for Medicaid beneficiaries. The MOU does not merely require Medicaid participation by the CCF to gain a CON; specific Medicaid percentage must be attained and maintained. As HFAM has stressed in written comments and in various meetings, most CCF admissions come from the hospital and many are Medicare Part A stays.[1]

Mandating a specific Medicaid percentage to be retained in a Center is contrary to TCOC innovation as hospitals and Centers seek to establish systems for effective discharge planning transition from the hospitals to Centers and then to home, avoiding rehospitalizations whenever possible. There is not a logical basis for mandating that Centers, instead, maintain a specific percentage of Medicaid beneficiaries when the data indicates that there is no Medicaid access to care problem. We urge a Reform Recommendation to eliminate the Medicaid MOU percentage.

Thank you for the opportunity to comment on these important matters. We wish to reiterate our support for this overall reform effort as the Report reflects. We ask that these comments be taken into account.

Be well,



Joseph DeMattos, Jr.
President and CEO

CC: The Honorable Lawrence J. Hogan, Jr., Governor of Maryland
The Honorable Robert R. Neall, Secretary, Maryland Department of Health
The Honorable Thomas "Mac" Middleton, Chair of the Senate Finance Committee
The Honorable Delores G. Kelley, Chair-Elect of the Senate Finance Committee
The Honorable Brian J. Feldman, Vice Chair-Elect of the Senate Finance Committee
Mr. Howard Sollins, ESQ
HFAM Board

[1] Days of care provided to Medicare beneficiaries who are also Medicaid beneficiaries do not "count" under an MOU. We also observe that a prior MHCC reduction of the MOU percentage by 15.5% did not result in any problem Medicaid access to Center care. Even a further reduction in the percentage does not appear in the Report as a potential solution.

November 1, 2018

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

RE: COMAR 10.24.20: State Health Plan for Facilities and Services: Comprehensive Care Facility Services

Dear Ben:

Thank you for making the time to meet yesterday and for our continued positive partnership to establish a regulatory foundation under the State Health Plan that ensures continued access to quality care for Marylanders in need, recognizes the importance and value of post-acute and long-term care providers, and positions the health care delivery system to serve future need, while at the same time improving health care outcomes and bending the cost curve.

As I said at our meeting yesterday, the proceedings on October 15, 2018 were most unfortunate in tone and substance. Maryland's post-acute and long-term care providers, many of them this week announced by U.S. News and World Report as among the best centers in the nation, were mischaracterized as resistant to change, not innovative, and were wrongly accused of engaging in last-minute efforts to block adoption of the draft COMAR 10.24.20: State Health Plan for Facilities and Services: Comprehensive Care Facility Services regulation. Of course, none of those assertions are true, nor are they representative of our historically productive working relationship with the Commission.

Speaking to the substantive issues of COMAR 10.24.20: State Health Plan for Facilities and Services: Comprehensive Care Facility Service, we appreciate that the draft approved by the Commission for public comment included several of the proposed changes, including the need for a longer look-back period of the CMS Five-Star Ratings to assess quality, reinstating the ability to seek a Medicaid Memorandum of Understanding (MOU) adjustment, considering that a new facility needs a two year ramp up period before a finding of new need in a jurisdiction is made (most immediately Prince George's County), and allowing the presentation of information concerning the role of certain former owners versus a blanket disqualification.

Nevertheless, as I explained yesterday and at earlier MHCC proceedings, we continue to have serious concerns that need to be addressed as we move forward.

First, we believe that maintaining a mandatory Medicaid percentage in the MOU is not sound policy. No one has refuted that there is ample access for services to Medicaid beneficiaries in existing facilities. Moreover, in an environment in which controlling the total cost of care is paramount, it does not make sense to mandate that substantial portions of existing capacity be used by long-term nursing facility patients. The Commission did not explain the need or impact of changing the current 15.5% offset in the MOU calculation to a percentage of a statewide percentile. The goal should be to ensure Medicaid access by requiring participation, but not to constrain innovation by unnecessarily imposing an MOU percentage; a position supported by Maryland Department of Health leaders during our most recent work group meeting at the Maryland Health Care Commission. Either the percentage should be eliminated or, at a minimum, the current offset of 15.5% should be increased substantially across the board.

Second, while we appreciate the broader range of data used to evaluate the Five Star rankings of prospective applicants, it should not be a barrier to applying. Rather, Five Star is just one source of information to be evaluated and considered. Five Star rankings are periodically changed by the Centers for Medicare and Medicaid Services (CMS) for reasons completely unrelated to facility performance; they can be "frozen" and new and/or different measures can be imposed. A facility's historical Five Star ranking is not retroactively changed when there is a successful Informal Dispute Resolution, Independent Informal Dispute Resolution or Departmental Appeals Board appeal or settlement. Under the Commission's approach, an agreement or resolution with CMS of a survey deficiency leaves the facility disadvantaged under the proposed CON process. We are happy to discuss other tools for considering quality instead of elevating Five Star to the threshold standard, for example Pay for Performance.

Third, we remain strongly opposed to the addition of capacity, including the addition of new facilities, in the absence of bed need through the new exceptions the draft chapter proposes.

While well intentioned, the docketing exception as outlined will have a negative impact on current quality care. This relates both to the exception where there is a certain Five Star ranking among a percentage of facilities in a jurisdiction or based on a hospital agreement that aspires to benefit efforts to constrain the Total Cost of Care. The harm of new capacity in the absence of need is indiscriminate and equally damaging to facilities that have been making substantial investments in facilities, staff and services.

This is particularly true in relation to the provision relating to hospital arrangements labeled as addressing the Total Cost of Care. The creation of new capacity without demonstrated need will have a negative impact on the current Medicare/Medicaid payer mix of existing quality post-acute and long-term care providers, ultimately lowering census, revenues and services of successful centers, creating a two-tier care environment.

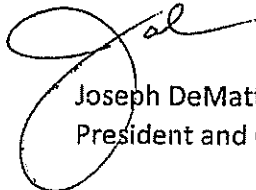
Furthermore, this docketing exception as outlined assumes that existing providers would be unwilling or incapable of partnering in innovation relative to the Total Cost of Care Contract, which has not proven to be the case. As I explained yesterday, I know of many post-acute and long-term care providers that want to partner equally with hospitals in total cost of care to improve clinical outcomes, get people home healthier and faster, while also bending the total cost of care curve.

I also note here that our reading of the COMAR 10.24.20: State Health Plan for Facilities and Services: Comprehensive Care Facility Services approved on October 15 reads: "(e) An applicant for this docketing exception ~~must~~ [shall] demonstrate that a project adding additional bed capacity in the jurisdiction is necessary in order for the cost-reducing agreement between it and one or more hospitals to be effectively implemented; and that it meets all." I don't think this is a "must" as you outlined yesterday.

Finally, we note that in advance of the meeting we sent to you and MHCC an amendment to the proposed Total Cost of Care docketing exception that would have addressed our concerns. We also agree with Commissioner Pollak's direction during the proceedings of October 15 that the Minutes of the committee reflect that a new applicant under this exception would have to prove that no existing provider was capable or willing to undertake the identified innovation; this suggestion for the Minutes is not a regulation, nor does it cure underlying defects in the concept.

Again, we appreciate the changes your team made to the draft as a result of our work together. As the adopted Chapter is published for comment, we will comment and work with you and your team at MHCC to find resolution to outstanding issues. While it is not the norm for regulatory agencies to make modifications post-adoption, we hope that MHCC will take a page from its earlier proceedings on Cardiac Services and work with us to get this important Chapter to a mutually agreeable place that serves the future needs of Marylanders.

Be well,



Joseph DeMattos, MA
President and CEO

cc: Robert R. Neall, Secretary, Maryland Department of Health
Webster Ye, Deputy Chief of Staff, Maryland Department of Health
Tiffany Robinson, Deputy Chief of Staff, Office of the Governor
Katie Wunderlich, Executive Director, Health Services Cost Review Commission
Howard Sollins, Baker Donelson
Danna L. Kauffman, LifeSpan Network
HFAM Board of Directors

November 14, 2018

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Ben:

I hope this letter finds you well, and as always, I thank you for all that you do. I was unable to make the meeting last week because of a meeting in Annapolis, however I have reviewed in detail the PowerPoint deck from the meeting. As you know, HFAM and LifeSpan are coordinating efforts on this front and we continue have serious concerns on what is proposed.

HFAM represents the majority of skilled nursing and rehabilitation centers in Maryland who provide the majority of both Medicaid and Medicare funded care in the long-term and post-acute care setting. On behalf of our provider community, HFAM remains opposed to the following recommendation – PowerPoint Recommendation #2:

"allow docketing of alternative models for post-acute care that is endorsed by the HSCRC staff as a viable approach for reducing the total cost of care consistent with HSCRC's TCOC model." Draft Report #2 – "create the ability for the waiver of CON requirements for a capital project that is endorsed by the HSCRC as a viable approach for reducing the total cost of care consistent with HSCRC's TCOC model and alternative models for post-acute care."

What is presently proposed, creating new post-acute care capacity absent demographic need for the first time in Maryland, could result in serious unintended consequences for Marylanders already receiving quality care in existing centers; these centers are already adapting and innovating in the Total Cost of Care environment.

The docketing exception as outlined will have a negative impact on current quality care innovation. This relates both to the exception where there is a certain Five Star ranking among a percentage of facilities in a jurisdiction or based on a hospital agreement that aspires to benefit efforts to constrain the Total Cost of Care. The harm of new capacity in the absence of need is indiscriminate and equally damaging to facilities that have been making substantial investments in physical plant, staff and services.

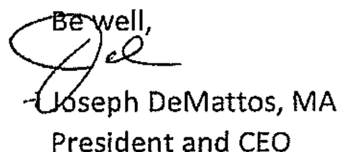
This is particularly true in relation to the provision relating to hospital arrangements labeled as addressing the Total Cost of Care. The creation of new capacity without demonstrated need will have a negative impact on the current Medicare/Medicaid payer mix of existing quality post-acute and long-term care providers, ultimately lowering census, revenues and services of successful centers, creating a two-tier care environment.

Just as continuing the memorandum of understanding in what is currently proposed by MHCC is not supported by any particular lack of availability or policy objective, the proposed docketing exceptions attempt to solve an unidentified lack of innovation in the Maryland post-acute and long-term care marketplace. Trust me - especially in a Total Cost of Care environment, the best providers are focused on quality, innovation, credibility and partnership across the continuum of care.

HFAM and our members are actively involved with Secretary Neall, partnering with Maryland hospitals and other providers as the Maryland Model moves to a more integrated Total Cost of Care environment and we believe that the docketing exceptions for skilled nursing and rehabilitation centers are premature at this time. We also believe that these important innovations relative to CON will be best achieved if we reach consensus on draft rules prior to publication in the Maryland Register.

Pursuant to our letter to you on November 1, 2018 (attached), we appreciate the changes your team made to the draft as a result of our work together. We look forward to our continued positive partnership as we work together to get this important initiative to a mutually agreeable place that serves the future needs of Marylanders.

Be well,



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